FDCH CACFP ENROLLMENT FORM

1. Participant Information: (To be completed by Parent/Guardian)

☐ **Participants are related to the Provider**

Participant's Last Name	Participant's First Name	Date of Birth	Normal/Typical Hours of Care			Normal/Typical Days of Care (Circle all that apply)							Meals Normally Eaten (Circle all that apply)					
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN

***Parent/Guardian works multiple shifts and participants may be in care different days/hours ____yes ____no**

Guide:
Normal hours of care: Please insert the usual arrival time and the usual departure time. Indicate a.m. or p.m.
Normal days of care: Please circle the days of the week the participant(s) are usually in attendance at the facility (M=Monday;T=Tuesday;W=Wednesday;Th=Thursday;F=Friday;Sa=Saturday;Su=Sunday)
Meals Normally Eaten-Please circle the meals the participants usually eat at the facility.
(B=Breakfast; AM=AM Supplement; L=Lunch; PM=PM Supplement; S=Supper; LN=Late Night Supplement)

2. Do you supply any food to the center for the participant's meals due to medical or religious reasons?
If **Yes**, please list foods supplied:

_____

3. Signature and Parent/Guardian Information:

_____

Parent/Guardian Signature **Date *(Parents date form)***

_____

Print Name: **Home Telephone Number:** **Work Telephone Number:**

_____

Address: **City:** **State:** **Zip Code:**

For Provider Use Only. Do not write below this line.

Signature of Provider: _____ **Date:** _____

Date the participant withdrew: _____

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Washington, D.C. 20250-9410;
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(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider."
**7 CFR 226.15 (e)(2)*